Test Data for §170.205(s)(1) Transmission to public health agencies – health care surveys: create health care survey information for electronic transmission in accordance with the standard specified in §170.205(s)(1)

Standard
§ 170.205(s)(1) HL7 Implementation Guide for CDA Release 2: National Health Care Surveys (NHCS), Release 1.1 DSTU – US Realm, (incorporated by reference in § 170.299).

A spreadsheet titled [insert spreadsheet title here and hot link it] can be used in tandem with this document. It may be helpful for those certifying the implementation of § 170.205(s)(1) HL7 Implementation Guide for CDA Release 2: National Health Care Surveys (NHCS), Release 1.1 DSTU – US Realm, . It presents the same test data contained in this document but also includes other metadata that may help technical implementers. Using these two documents, it is expected that a medical record will be created in the EHRS to reflect the case of the Emergency Department, inpatient, and/ or outpatient visit represented by the data offered. Once the medical record has been entered into the system, the testing of the document creation implementation can be executed.

Ambulatory Setting

This section contains test data to be used as an illustration of 170.205(s)(1) in the ambulatory setting. The data contained within this document are intended to provide a patient record to be formatted according to the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: National Health Care Surveys (NHCS), Release 1.1 DSTU – US Realm) and subsequently transmitted.

TD170.205(s)(1) – 1: Ambulatory

To exemplify 170.205(s)(1), the following clinical scenario will be employed.

Mr. Gary E. Goe is a 57 year old Black male with a history of obesity, asthma, hypertension, coronary artery disease, and myocardial infarction. His hypertension has been controlled by Atenolol and Methyldopa; however, Mr. Goe recently stopped his medication due to cost and lack of health insurance after losing his job. He presented to Sunset Family Practice Associates complaining of recurring headaches. Debbie Doe, RN, checked Mr. Goe's vital signs shortly after his arrival at the clinic. His blood pressure was elevated with a rapid, regular pulse. His temperature was normal. He was seen by Dr. Persona who ordered a dose of Lisinopril to be administered at the clinic. Mr. Goe's vital signs were checked by Debbie Doe, RN, 30 minutes after the Lisinopril was administered. Mr. Goe's blood pressure had lowered and he was not complaining of any headache. Nurse Doe provided weight-reducing diet education. He was instructed to fill prescription, take as directed and return for follow-up in 1 week to less than 2 months.

A) Patient Demographics

- Patient name: Gary E. Goe
- Sex: M

- Date of birth: 08/20/1958
- Race: Black [Race_CDC:2054-5]
- Ethnicity: Hispanic or Latino [Ethnicity_CDC:2135-2]
- Patient Address1: 125 Green Circle
- Patient City: Any Town
- Patient State: AZ
- Patient Zip: 87020
- Patient Social Security Number: 117255095
- Patient Medicare Number: 117255095A
- Marital Status: Married [MaritalStatus:M]

B) Encounter Information
- Encounter Number: 347890
- Medical Record Number: 54783255
- Type of clinic/location where visit occurred: Family Medicine Clinic [Healthcare Provider Taxonomy:1117-1]
- Patient seen in clinic before: Yes
- Date of Admission: 10/19/2015
- Time of Admission: 9:15 a.m.
- Date of Discharge: 10/19/2015
- Time of Discharge/Departure: 10:15 a.m.
- Discharge Disposition:
    - Return in 1 week to less than 2 months: [PHINVADS:PHC1397]
    - Refer to cardiologist - Refer to other physician/provider: [SNOMED: 449221000124102]

C) Provider Information
- Physician NPI: [NPI Identifier: 1245319799]
- Types of Care Providers Seen - Family Medicine [Healthcare Provider Taxonomy:207Q00000X]
- Patient seen by PCP: Yes
- Referral visit: No

D) Care Team
- Dr. Laura Persona, Tel, 543-555-2244, Sunset Family Practice Associates, 103 Riverside Blvd., Any Town, AZ 87020
- Debbie Doe, RN, Tel, 543-555-2244, Sunset Family Practice Associates, 103 Riverside Blvd., Any Town, AZ 87020

E) Patient Information Section
- Patient Residence Observation
    - Patient Residence Type: patient's home [SNOMED: 394778007]

F) Payer Sources
- Commercial Managed Care HMO [SOP:511]

G) Clinician's Notes
- Targeted History and Physical Notes: [LOINC:34138-8]

H) Social History
- Smoking Status - Meaningful Use
    - Former Smoker [SNOMED:8517006]

I) Medications Section
- Lisinopril 30 mg ORAL tab [RxNorm:205326]

- Frequency: 1
- Event: EVN
- Start Date/Time: 10/19/2015 at 9:30 a.m.
- Stop Date/Time: 10/19/2015 at 9:30 a.m.

- Lisinopril 30 mg ORAL tab [RxNorm:205326]
  - Frequency: QD
  - Event: INT
  - Start Date/Time: 10/19/2015 at 9:00 a.m.
  - Stop Date/Time: NONE
- Atenolol 50 mg ORAL tab, [RxNorm:197381]
  - Frequency: QD
  - Event: EVN
  - Start Date: 6/12/2013 at 9:00 a.m.
  - Stop Date: 8/12/2015 at 9:00 a.m.
- Methyldopa 250 mg ORAL tab, [RxNorm:316283]
  - Frequency: QD
  - Event: EVN
  - Start Date/Time: 6/12/2013 at 9:00 a.m.
  - Stop Date/Time: 8/12/2015 at 9:00 a.m.
- Ibuprofen 400 mg ORAL tab, [RxNorm:317388]
  - Frequency: QD
  - Event: EVN
  - Start Date/Time: 10/20/2015 at 9:00 a.m.
  - Stop Date/Time: NONE

J) Outpatient Encounters Section

- Episode of Care Observation
  - Initial or follow up visit: Follow up visit [SNOMED: 185389009]
- Major Reason for Visit
  - Is this visit for a new problem?: New problem (<3 mos): [PHIN VADS:PHC1265]
- Number of Visits in the Last 12 Months
  - How many visits in previous 12 months (excluding this visit): 3
  - Was patient referred: No

K) Patient's Reasons for Visit Section

- Reason for Visit: Headache [SNOMED:25064002]

L) Problems Section

- Asthma Diagnosis Observation
  - Asthma [SNOMED:195967001]
  - Asthma Severity: Mild to moderate [SNOMED:371923003]
  - Asthma Control: Condition determination, fairly well controlled [SNOMED:12650007]
- Co-morbid Condition Observation
  - Coronary Arteriosclerosis [SNOMED:53741008]
  - Obesity [SNOMED:414916001]
  - History of Myocardial Infarction [SNOMED:399211009]
  - Anxiety Disorder [SNOMED:197480006]
- Primary Diagnosis Observation (V2): Essential Hypertension [SNOMED:59621000]

M) Results Section
Laboratory Tests and Values/Results

- Cholesterol in Serum/Plasma [LOINC: 2093-3]
  - Result: 225 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:30 p.m.
  - Result Status: Completed
  - Result Interpretation: Above high threshold [HL7 Observation Interpretation:HX]
- Cholesterol in HDL in Serum/Plasma [LOINC:2085-9]
  - Result: 48 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:35 p.m.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Cholesterol in LDL in Serum/Plasma [LOINC:2089-1]
  - Result: 145 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:30 p.m.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Triglyceride in Serum/Plasma [LOINC:2571-8]
  - Result: 188 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:32 p.m.
  - Result Status: Completed
  - Result Interpretation: Above high threshold [HL7 Observation Interpretation:HX]
- Hemoglobin A1C/Hemoglobin in Total in Blood [LOINC:4548-4]
  - Result: 5.1% Hgb
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:50 p.m.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Glucose in Blood [LOINC:2339-0]
  - Result: 99 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:43 p.m.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Creatinine in Serum/Plasma [LOINC:2160-0]
  - Result: 1.3 mg/dL
  - Test Date/Time: 10/19/2015 at 9:40 a.m.
  - Result Date/Time: 10/19/2015 at 9:42 p.m.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]

N) Services and Procedures
- Weight-reducing diet education [SNOMED CT: 266724001]

O) Vital Signs Section
- Date/Time Vital sign measurement on arrival: 10/19/2015 at 9:30 a.m.
    - Author Participation
        - Registered Nurse [Health Care Provider Taxonomy:163W00000X]
    - Height [LOINC:8302-2]: 178 cm
    - Weight measured [LOINC:3141-9]: 113.4 kg
    - BMI [LOINC:39156-5]: 35.8 kg/m2
    - Body Temperature [LOINC:8310-5]: 37.2°C
    - Blood Pressure Systolic [LOINC:8480-6]: 168 mmHg
    - Blood Pressure Diastolic [LOINC:8462-4]:101 mmHg
    - Heart Rate [LOINC:8867-4]: 90/min
    - Respiratory Rate [LOINC:9279-1]: 24/min
    - PulseOx [LOINC:2710-2]: 98%

- Date/Time Vital sign measurement last taken: 10/19/2015 at 10:00 a.m.
    - Author Participation
        - Registered Nurse [Health Care Provider Taxonomy:163W00000X]
    - Body Temperature [LOINC:8310-5]: 37.2°C
    - Blood Pressure Systolic [LOINC:8480-6]: 146 mmHg
    - Blood Pressure Diastolic [LOINC:8462-4]: 86 mmHg
    - Heart Rate [LOINC:8867-4]: 77/min
    - Respiratory Rate [LOINC:9279-1]: 18/min
    - PulseOx [LOINC:2710-2]: 100%

Emergency Department Setting

This section contains test data to be used as an illustration of 170.205(s)(1) in the emergency department setting. The data contained within this document are intended to provide a patient record to be formatted according to the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: National Health Care Surveys (NHCS), Release 1.1 DSTU October 2015) and subsequently transmitted.

TD170.205(s)(1) – 1: Emergency Department

To exemplify 170.205(s)(1), the following clinical scenario will be employed.

Ms. Loe, a 61yo Asian female, presents to the emergency department having suffered blunt force trauma to the face, approximately one hour before arrival. She is agitated and appears drunk. The patient is alert and oriented x 2 but has garbled speech and is a poor historian. She is treated with IV fluids and IV Ativan to control agitation. Fluorescein eye exam to the L eye found no abnormalities. Head CT revealed maxillary sinus fracture. ETOH level 300. Pt was transferred to the ED observation unit and subsequently admitted to a medical surgical nursing unit for further observation and evaluation.

A) Patient Demographics

- Patient name: Laura L. Loe
- Patient address: 220 High Ave.; Apartment #17; Any Town; Massachusetts; 65432
- Patient SSN: 102-77-9123
- Patient Medical Record Number: N0003-507-2475
- Patient Encounter Number: 222244444
- Patient marital status: Divorced
- Sex: F
- Date of birth: 3/6/1953
- Race: Asian
- Ethnicity: Not Hispanic or Latino

B) Patient Information Section

- Patient Residence Observation
    - Patient Residence Type: patient's home [SNOMED: 394778007]

C) Provider Information

- Physician NPI: [NPI Identifier: 3345566774
    - Types of Care Providers Seen –
        - Emergency Medicine [Healthcare Provider Taxonomy: 207P00000X]
        - Registered Nurse [Healthcare Provider Taxonomy:163W00000X]
    - Patient seen by PCP: No

D) Triage Section

- Was patient triaged? – Yes
- Triage Level Assigned Observation
    - Triage System: Emergency Severity Index [LOINC:75636-1]
    - Triage Level: 2

- On Oxygen on Arrival Observation: No
- Pain Assessment Scale Observation: UNK
- Pain Level: 2

E) Emergency Department Encounters Section

- Discharge Disposition: Admitted to this hospital [SNOMED:432661000124104]
- Date/Time Provider Contact: Jan. 3, 2015 12:51 a.m.
- Discharge Status: Patient discharged alive
- Episode of Care Observation
    - Initial patient assessment [SNOMED:315639002]
- Major Reason for Visit
    - New problem (<3 mos. Onset) [PHINVADS:PHC1265]
- Patient Seen in this ED in last 72 Hours and Discharged: No [LOINC:75611-4]
- Point of Origin Observation: Community environment [SNOMED:385202004]
- Transport Mode to Hospital Observation: Ground transport ambulance [SNOMED:44613004]
- Clinical Document
    - Type of Clinical Note: History of Present Illness [LOINC:10164-2]
    - Author: Kevin Koe, MD (NPI: 3345566774)
    - Date/Time of Clinical Note: Jan 3, 2015 07:24am
    - Content: 61 YO Asian F with unknown PMH BIBA s/p blunt trauma to face following altercation with nephew late last night. Per EMS, patient was hit with bottle, unknown number of times or if additional instrument was used. +etoh, difficult to obtain history from patient 2/2 agitation. Unknown LOC, denies N/V, HA, blurry vision, extremity weakness/paresthesias, cp or sob. The history is provided by the patient and the EMS personnel. The history is limited by the condition of the patient. No language interpreter was used.

    - Type of Clinical Document: Triage note [LOINC: 54094-08]
    - Author: Kay Krokett, RN (NPI:)
    - Date/ Time of Clinical Note: Jan 3, 2015 07:24am
    - Content: Agitated, A&Ox2. EMS states pt. “hit with bottle in face”, L facial swelling and bruising. Unable to state a number on 0-10 pain scale. ++etoh.

F) Hospital Admission Encounter

- Date/Time Bed Requested for Hospital Admission Order or Transfer: 1/3/2015 11:00 a.m.
- Discharge Status Observation: Patient discharged alive (SNOMED CT: 371827001)
- Hospital Discharge Diagnosis: maxillary fracture, unspecified (ICD10CM: S02.401A)
- Listed for Admission to Hospital: 1/3/2015 10:26 a.m.
- Service Delivery Location: Inpatient medical/surgical ward [HL7 HealthcareServiceLocation: 1061-1]
- Dr. Aaron Admit, NPI 555-555-1006: Hospitalist (208M00000X)

G) Observation Unit Stay Encounter

- Observation Unit Admit Date/Time: 1/3/2015; 07:21 a.m.
- Observation Discharge Date/Time: 1/3/2015; 11:21 a.m.

H) Admission and discharge information

- Date and time of arrival: 1/3/2015; 12:21 a.m.
- Date and time of discharge: 1/3/2015; 11:30 a.m.

I) Expected source(s) of payment

- BC Managed Care – HMO [Source of Payment Typology:611]

J) Medications

- 1 ML Lorazepam 4 MG/ML Injection [RxNorm: 206820], Start: Jan 3, 2015 02:00am, Stop: Jan 3, 2015 10:00am
- Tetracaine 10 MG/ML, [RxNorm: 328652], Jan 3, 2015 09:00am SUBCUTANEOUS [SNOMEDCT: C38299]
- Acetaminophen 500 MG [RxNorm: 315266], Start: Jan 3, 2015 02:00am, Stop: Jan 3, 2015 10:00am one q 4h
- Normal Saline 100cc/hr [RXNorm]: Start: Jan 3, 2015 02:00am, Stop: Jan 3, 2015 10:00am; INTRAVENOUS [NCI Thesaurus: C38276]

K) Primary Diagnosis:

maxillary fracture, unspecified [ICD10CM: S02.401A; Start: 1/3/2015; 01:21 a.m.

L) Reason for Visit

- Unspecified injury of face, initial encounter [ICD-10: S09.93XA]

Active Problems with diagnoses

- maxillary fracture, unspecified [ICD10CM: S02.401A]; Start: 1/3/2015; 01:21 a.m.
- Essential hypertension [SNOMED CT: 59621000] 3/22/2010

M) Services and Procedures

- CT of head without contrast followed by contrast material [CPT – 70470]
- Comprehensive Ophthalmological service [CPT – 92004]

N) Vital Signs (2.16.840.1.114222.4.11.3591) (Value Set: Vital Sign Result urn:oid:2.16.840.1.113883.3.88.12.80.62)

Initial Vital signs

- Height: 158 cm
- Weight: 64 kg
- Blood Pressure: ***systolic*** -169/ ***diastolic*** 89 mmHg
- Pulse: 118/ min
- Respiratory Rate 18/ min
- Temperature: 36.4 Cel
- Pulse Ox: 100%
- BMI: 25.6

Last Vital signs

- Blood Pressure: systolic -169/ diastolic 89 mmHg
- Pulse: 118/ min
- Respiratory Rate 18/ min
- Temperature: 36.4 Cel
- Pulse Ox: 100%

O) Results Section

Laboratory Tests and Values/Results

- WBC Count - Blood [LOINC: 6690-2]
  - Result: 10.8 K/mcl
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am

- Result Status: Completed
- Result Interpretation: Normal [HL7 Observation Interpretation:N]

- RBC Count Blood [LOINC: 789-8]
  - Result: 5.15 (M/mcl)
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Hemoglobin [LOINC: 718-7]
  - Result: 15.2 g/dl
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Hematocrit [Volume Fraction] of Blood by Automated count [LOINC:2571-8]
  - Result: 46.4%
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Above high threshold [HL7 Observation Interpretation:HX]
- Sodium in Serum or Plasma [LOINC: 2951-2]
  - Result: 139 meq/L
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Potasium in Serum or Plasma [LOINC: 2823-3]
  - Result: 10.8 K/mcl
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Chloride in Serum or Plasma [LOINC: 2075-0]
  - Result: 105
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Carbon dioxide, total in Serum or Plasma [LOINC: 2028-9]
  - Result: 22 meq/L
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Anion gap 3 in Serum or Plasma [LOINC: 10466-1]
  - Result: 12
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Above high threshold [HL7 Observation Interpretation:HX]
- Urea nitrogen in Serum or Plasma [LOINC: 3094-0]
  - Result: 13 mg/ dL
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Creatinine in Serum/Plasma [LOINC:2160-0]
  - Result: 0.9 mg/dL

- Test Date/Time: Jan 3, 2015 02:00am
- Result Date/Time: Jan 3, 2015 04:10am
- Result Status: Completed
- Result Interpretation: Normal [HL7 Observation Interpretation:N]

- Calcium in Serum or Plasma [LOINC: 17861-6]
  - Result: 10 mg/ dL
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Albumin in Serum or Plasma by Bromocresol green (BCG) dye binding method [LOINC: 61151-7]
  - Result: 5.0 g/dL
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am.
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Glomerular filtration rate/1.73 sq M.predicted by Creatinine-based formula (MDRD) [LOINC: 33914-3]
  - Result: >60 mL/min/173m2
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Above high threshold [HL7 Observation Interpretation:HX]
- Osmolality of Urine [LOINC: 2695-5]
  - Result: 282
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Ethanol [Mass/volume] in Blood [LOINC: 5640-8]
  - Result: 311
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Prothrombin time (PT) in Platelet poor plasma by Coagulation assay [LOINC: 5902-2]
  - Result: 10.4s
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: below low threshold [HL7 Observation Interpretation:LX]
- INR in Blood by Coagulation assay [LOINC: 34714-6]
  - Result: 0.9
  - Test Date/Time: Jan 3, 2015 02:00am
  - Result Date/Time: Jan 3, 2015 04:10am
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]

P) Immunizations administered (2.16.840.1.113762.1.4.1010.6)

- Influenza virus vaccine, [CVX: 88], 10/2/2010, Completed

Inpatient Setting

This section contains test data to be used as an illustration of 170.205(s)(1) in the inpatient setting. The data contained within this document are intended to provide a patient record to be formatted according to the Consolidated CDA IG (HL7 Implementation Guide for CDA Release 2: National Health Care Surveys (NHCS), Release 1.1 DSTU October 2015) and subsequently transmitted.

TD170.205(s)(1) – 2: Inpatient

To exemplify 170.205(s)(1), the following clinical scenario will be employed:

Mr. John Williams is a 65-year-old Black male with a history of type II diabetes and hypercholesterolemia controlled on NovoLog, Lantus, and Lipitor. He presented to the emergency department at Local Community Hospital on October 2, 2012 with a three hour history of increasingly severe chest pain radiating into left arm and lower jaw, which began immediately after vigorous exercise. Mr. Williams underwent an EKG administered by Nancy Nightingale, RN, which demonstrated no abnormalities. He was admitted by Dr. Alan Admit, placed on oxygen therapy and underwent serial troponins. He was subsequently discharged on hospital day #2 with a diagnosis of angina and instructions to follow up with his primary care physician.

A) Patient Demographics

- Patient name: John Williams, Jr.
- Patient address: 123 Main Street; Apartment 2; Big City; Maine; 24387
- Patient Residence Type: patient's home [SNOMED CT: 394778007; Patient Residence (NCHS) (value set name); 2.16.840.1.114222.4.11.7402]
- Point of Origin: Community Environment. [SNOMED CT: 285202004; Point of Origin (NCHS) (value set name); 2.16.840.1.114222.4.11.7359 (value set OID)].
- Patient SSN: 555-432-1234
- Patient Medicare number: 555-432-1234A
- Patient Medical Record Number: 2539781
- Patient Encounter Number: 25341
- Patient marital status: Married
- Sex: M
- Date of birth: 4/7/1947
- Race: Black
- Ethnicity: Not Hispanic or Latino

B) Care Team – NPIs and types of providers seen (urn:oid:2.16.840.1.113883.6.101 Healthcare Provider Taxonomy (HIPAA)

- Nancy Nightingale, RN, NPI - 555-555-1014 : Nurse practitioner – Acute Care 363LA2100X)
- Dr. Aaron Admit, NPI 555-555-1006: Hospitalist (208M00000X)

C) Admission and discharge information

- Date and time of arrival: 10/2/2012; 11:30 a.m.
- Date and time of discharge: 10/3/2012; 1:15 p.m.
- Priority of admission: Urgent admission (SNOMEDCT urn:oid:2.16.840.1.113883.6.96

448381000124100)

- Number of days in ICU: 0
- Discharge disposition: Discharged to home or self-care (urn:oid:2.16.840.1.113883.12.112)

D) Expected source(s) of payment (2.16.840.1.113883.3.221.5)

- Medicare FFS (121)
- AARP Supplemental Insurance (523)

E) Smoking Status: Current every day smoker [SNOMED-CT: 449868002]

F) Medications

- Insulin, Aspart, Human [NovoLog], [RxNorm: 284810], ***Select value*** (15, 20, 25) units, three times daily before meals, Sub-cutaneous, Start: 1/9/2009, Active
- Lantus 300 UNT per 3 ML OptiClik Pen, [RxNorm: 847232], 1/9/2009, Sub-cutaneous, ***Select value*** (30, 40, 50) units, once daily before sleep, Active
- Atorvastatin 40 MG Oral Tablet [Lipitor], [RxNorm: 617320], 8/8/2008, once daily, Active
- Aspirin 81 MG Oral Tablet, [RxNorm: 243670], once daily, Start: 10/2/2012, Active

G) Admission Diagnosis

- Angina, [SNOMED CT: 194828000], Start: 10/2/2012, Active

H) Active Problems with diagnoses [SNOMED CT and ICD-10]

- Angina, [SNOMED CT: 194828000] [ICD-10 I20.9], Start: 10/2/2012, Active
- Diabetes Mellitus Type 2, without complications, [SNOMED CT: 44054006][ICD-10 E11.9] Start: 1/9/2009, Active
- Hypercholesterolemia, [SNOMED CT: 13644009] [ICD-10 E78.0], Start: 8/8/2008, Active
- Tobacco dependence syndrome [SNOMED CT: 89765005] Start: 6/1/1970, Active

I) Procedures

- Electrocardiographic Procedure, [SNOMED CT: 29303009] or [CPT: 93000], 10/2/2012
- Intranasal oxygen therapy, [SNOMED-CT: 71786000], 10/2/2012

J) Vital Signs (2.16.840.1.114222.4.11.3591) (Value Set: Vital Sign Result urn:oid:2.16.840.1.113883.3.88.12.80.62)
Initial Vital Signs

- Height: 178 cm
- Weight: 82 kg
- Blood Pressure: ***systolic*** 158/***Select diastolic*** 92 mmHg
- Pulse: 95/ min
- Respiratory Rate 16/ min
- Temperature: 38.0 Cel
- Pulse Ox: 99%
- BMI: 25.6

Last Vital signs

- Weight: 82 kg
- Blood Pressure: ***systolic*** -144/ ***diastolic*** 88 mmHg
- Pulse: 86/ min
- Respiratory Rate 20/ min
- Temperature: 36.8 Cel
- Pulse Ox: 99%

K) Laboratory Tests and Values/ Results

- Sodium in Serum or Plasma [LOINC: 2951-2]
  - Result: 139 meq/L
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Potasium in Serum or Plasma [LOINC: 2823-3]
  - Result: 3.9 mmol/L
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Chloride in Serum or Plasma [LOINC: 2075-0]
  - Result: 105
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Carbon dioxide, total in Serum or Plasma [LOINC: 2028-9]
  - Result: 25 meq/L
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Urea nitrogen in Serum or Plasma [LOINC: 3094-0]
  - Result: 15 mg/ dL
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Creatinine in Serum/Plasma [LOINC:2160-0]
  - Result: 1.0 mg/dL
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Glocose in Serum or Plasma [LOINC: 2339-0]
  - Result: 190 mg/ dL
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 2, 2015 1:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Troponin T [LOINC: 6598-7]
  - Result: 0.1 ng/mL
  - Test Date/Time: Oct 2, 2012 12:00pm
  - Result Date/Time: Oct 3, 2015 3:00pm
  - Result Status: Completed
  - Result Interpretation: Normal [HL7 Observation Interpretation:N]
- Troponin T [LOINC: 6598-7]

- Result: 0.1 ng/mL
- Test Date/Time: Oct 2, 2012 19:00pm
- Result Date/Time: Oct 3, 2015 3:00pm
- Result Status: Completed
- Result Interpretation: Normal [HL7 Observation Interpretation:N]

L) Immunizations administered (2.16.840.1.113762.1.4.1010.6)

- influenza virus vaccine, unspecified formulation, [CVX: 88], 10/2/2010, Completed

Notes